1343: B3 CORE BIOPSY SUSPICIOUS OF A PAPILLOMA: HOW SHOULD WE PROCEED?

Alan G. Dawson, George Ramsay, Tanja Gagliardi. *NHS Grampian, Aberdeen, UK.*

Aim: Papillomatous lesions of the breast, with or without atypia, are often reported as a B3 on core biopsy and proceed to surgical excision. This audit aimed to retrospectively assess the propensity for neoplasia to occur and whether surgical excision is appropriate.

Methods: A database of patients with a B3 core biopsy at a single Breast Unit between October 2005 and April 2012 was searched. Core biopsies of papillomas scoring B3 with subsequent surgical excision were included. Demographic parameters including patient age, pre-and post-operative size, and presence of atypia were recorded. Subsequent development of cancer was identified from follow-up data. Analysis of the data was performed using SPSS.

Results: Fifty patients with a median age of 62 years had a median pre-operative and post-operative lesion size of 12mm and 40mm, respectively. Atypia was evidenced in 11 patients on core biopsy. DCIS was present in nine patients at the time of excision and three patients subsequently developed a cancer. There was a significant association between DCIS at the time of excision and subsequent invasive disease ($p=0.048$, Fisher's exact test).

Conclusion: A B3 core biopsy suggestive of a papilloma without evidence of atypia can safely be removed by large volume core biopsy.

1372: PATHOLOGICAL EVALUATION OF THE STAGING AXILLARY LYMPH NODES: A NATIONAL SURVEY IN THE UNITED KINGDOM

Sreekumar Sundara Rajan, Rashmi Verma, Eldo Thomas, Kieran Horgan, Andrew Hanby, Sally Lane. *Leeds Teaching Hospitals NHS Trust, Leeds, UK.*

There is ongoing debate about the management of breast cancer patients with positive staging axillary lymph node (ALN). We aimed to investigate the practices followed by different pathology laboratories in evaluating staging ALN.

Methods: A structured questionnaire approved by the NHSBSP pathology Big 18 committee was circulated amongst all pathologists in the United Kingdom through the Breast Screening Quality Assurance Reference Centres.

Results: Amongst 160 respondents, the majority performed SLNB (92%) for staging. Most laboratories had a protocol for processing staging ALN (97%). Most laboratories examined the ALN after formalin fixation and paraffin embedding (FFPE) (85.6%). However a few used some initial intra-operative procedures such as PCR (7.5%), frozen section (3.8%) and touch imprint cytology (3.1%), with or without subsequent FFPE examination. Currently 33% perform serial sectioning of the FFPE blocks with the majority (75%) staining 3 sections using H&E. 67% performed standard sectioning at 1-2 mm followed by H&E evaluation of one section. Most units (85%) performed immunohistochemistry evaluation only when suspicious cells were detected in the H&E stained sections

Conclusion: There is considerable variation in the way lymph nodes are sectioned and evaluated histologically, however majority of the laboratories adhere to the national guidelines for evaluating staging ALN.

1399: THE INFLUENCE OF AGE ON BREAST CANCER TREATMENT

Caroline Mortimer[2], Hirah Rizki[1], Hannah Rizki[3], N. Garg[1]. [1] *Ipswich Hospital, Ipswich, UK;* [2] *Anglia Cancer Network, East Anglia, UK;* [3] *London School of Economics, London, UK.*

Aim: Published literature reports a bias towards under treating elderly patients with cancer. The aim of this study was to review treatments offered for primary breast cancer in patients over 70 to assess how age impacts on access to treatment.

Method: We reviewed data on 651 patients (mean age 80) from eight breast units across East Anglia between 1st April to 30 September 2010 and 2011. Adult Co-morbidity Evaluation-27 index (ACE-27) and Nottingham Prognostic Indicator (NPI) values were calculated. Data were analysed to identify associations between age and treatments offered.

Results: 451 (mean age 79) patients were suitable candidates for surgery (ACE-27 score ≤ 2). 82% were offered surgery (mean age 78). 152 (mean age 77) patients were eligible for chemotherapy (NPI score ≥ 3.5 and ACE-27 score <3), 15% were offered chemotherapy (mean age 73). Nearly all ER positive patients received hormonal treatment. In comparison, Herceptin was administered to 19% of patients who were HER2 positive, with a decline in use with increasing age.

Conclusion: Overall, we note access to standard treatments declined significantly with increasing age. However, we have not taken into consideration the performance status of these patients, this may impact on their suitability for systemic treatments.

1415: CANCELLATION AND NON-ATTENDANCE IN BREAST DAY CASE SURGERY: ARE ASYMPTOMATIC PATIENTS LESS LIKELY TO ATTEND?

K.L. Whitcroft, E. Martinou, N. Betambeau. *St George's Hospital, London, UK.*

Aim: High rates of cancellation and patient non-attendance (NA) for breast day surgery have been anecdotally noted in our institution. We aimed to determine rates and reasons for cancellation and NA in breast day surgery. For comparison, lower GI surgery was audited.

Methods: Three months of TheatreMan data and discharge summaries were retrospectively analyzed for breast and lower GI cancellation/NA rates. Patients who had not attended were contacted to identify reasons. Rates were compared using Fisher's exact test.

Results: 42 breast and 73 lower GI patients were scheduled; 6 (14%) and 14 (19%) patients were cancelled and 10 (23%) and 4 (5%) did not attend respectively. There was significantly higher NA in breast patients (18%, $p=0.019$). Cancellation rates were not significantly different (5%, $p=0.62$). NA was most frequently due to social circumstances/perception of need for operation.

Conclusion: Cancellation rates for both specialties were similar to those quoted elsewhere. NA was significantly higher in breast patients, which has not previously been explored in the literature. This may be due to low motivation to attend: breast conditions in day surgery are often benign and asymptomatic. Additional preoperative interventions (telephone/text reminders) may be beneficial to ensure attendance and maximize resources.

1457: DO AXILLARY SENTINEL LYMPH NODE MICROMETASTASES PREDICT INVOLVEMENT OF THE NON-SENTINEL LYMPH NODES IN BREAST CANCER?

Ashley Topps, Emma de Sousa, Katherine McNamara, Katherine Miller, Mohammed Absar. *North Manchester General Hospital, Manchester, UK.*

Aim: The management of patients diagnosed with micrometastases (tumour deposits $\leq$2.0mm but $>$0.2mm) on sentinel lymph node (SLN) biopsy is controversial. In particular, whether a completion axillary node clearance (cANC) can be avoided in selected patients because of the low prevalence of metastases in the non-SLNs. Our aim was to investigate whether micrometastases found on SLN biopsy predicts metastases in the non-SLNs.

Method: A retrospective review of all SLN biopsies performed between January 2008 and December 2012 was performed. In patients found to have micrometastases only on SLN biopsy, the pathology results of the cANC were obtained.

Results: 450 SLN biopsies were performed. Micrometastases only were found in 36 patients. 31 of these patients underwent a cANC and non-SLN metastases were found in 5 (16%). Of the patients with non-SLN metastases, on SLN biopsy they each had only one positive node and on the cANC specimen the median number of positive nodes found was 2 (range $1-3$). It was not possible to identify any specific criteria that could be used to exclude certain patients from undergoing cANC.

Conclusions: In patients with micrometastases on SLN biopsy, metastases in the non-SLNs are relatively common. These patients should therefore undergo cANC.

CARDIOTHORACIC SURGERY

0048: THE USE OF BIOLOGICAL IMPLANTS FOR SOFT TISSUE AND CHEST WALL RECONSTRUCTION IN THORACIC SURGERY IS SAFE EVEN IN CONTAMINATED ENVIRONMENTS

Eleanor Atkins, Laura Socci, Anupama Barua, Munib Malik, Anna Raurell, James Catton, Eveline Internullo, Antonio Martin-Ucar. *Nottingham University Hospitals NHS Trust, Nottingham, UK.*